

For Office Use Only: \$125.00 [] Check # _____
\$175.00 [] Check # _____
\$225.00 [] Check # _____

Application for Renewal of Kentucky Medical/Osteopathic License for Year 2005
Registration Fee: \$125.00

Please Note: Do Not Use This Form if Your Kentucky Medical License Was Inactive in 2004.

Late Registration (After March 1, but before April 1) may be made by payment of an additional \$50.00 penalty fee. After April 1, 2005, you will be imposed an additional \$100.00 fee.

Please answer all questions on this application.

Note: Intentional false answers or misrepresentation in applying for or procuring a license, registration or reactivation in Kentucky are grounds for disciplinary action, including denial or revocation of license, and are reported to the National Practitioner Data Bank and/or appropriate national professional credentialing organization. You must answer "yes" to any question if the event(s) described in that question has actually occurred. You must answer, "yes" in such circumstances even if you have been advised by an attorney or other person that you may answer "no". You must also answer "yes" in such circumstance even if the record of the event has been sealed or expunged by Court order, or has been designated "confidential" by the body involved. After answering "yes" to the appropriate question(s), you may advise the Board of any additional relevant information pertaining to your answer (i.e., record has been sealed or expunged, record is designated "confidential," attorney has advised that you properly answer "no"). The Board will consider this additional information, along with your answer(s), in determining the appropriate action.

If you have any question about whether or not you should answer "yes" to a question, you should err in favor of answering "yes" and providing an explanation, because any non-disclosure violation will likely result in denial of your application or disciplinary action against your license.

Name: _____

License No: _____

1) Mailing Address:

Street: _____

(Mailing address must be a street address; Post office address will no longer be accepted.)

City & State: _____ Zip Code: _____

2) Practice Address if Different from Mailing Address: _____

(Practice address must be a street address; Post office address will no longer be accepted.)

City & State: _____ Zip Code: _____

3) Principal KY Practice County: _____ Percent of Practice in that County: _____%

Average total number of hours worked per week: _____

4) Office Telephone Number: (_____) _____ - _____

5) E-Mail Address (For Office Use Only): _____

6) Do you intend to practice medicine in Kentucky? [] Yes [] No

If "NO" please specify reason for registering your Kentucky license: _____

7) Do you currently have hospital staff privileges within the Commonwealth of Kentucky? [] Yes [] No

8) Specialty:

9) Type of Practice:

<input type="checkbox"/> Hospital Based	<input type="checkbox"/> Resident/Fellow	<input type="checkbox"/> Military	<input type="checkbox"/> Retired
<input type="checkbox"/> Faculty	<input type="checkbox"/> Private Practice	<input type="checkbox"/> Research	<input type="checkbox"/> Semi-Retired
<input type="checkbox"/> Administrative Medicine	<input type="checkbox"/> Occupational Medicine	<input type="checkbox"/> Emergency Medicine	<input type="checkbox"/> Locum Tenens
			<input type="checkbox"/> Public Health/Government

Application for Registration of Kentucky Medical/Osteopathic License for Year 2005

Name: _____

License No.: _____

- 10) Since you last registered have you had any license, certificate, registration or other privilege to practice as a health care professional denied, revoked, suspended, probated, restricted, reprimanded, limited, or subjected to any other disciplinary action, by a state medical/osteopathic licensing board, or Federal, or International authority?
☐ Yes ☐ No
- 11) Since you last registered have you surrendered such credential, or placed it into an inactive status, to avoid disciplinary action or in connection with or in anticipation of a disciplinary investigation/action by the licensing authority of such jurisdiction?
☐ Yes ☐ No
- 12) Since you last registered have you been or are you currently under investigation by any State medical/osteopathic licensing board, Federal or International licensure authority or any drug licensure/enforcement authority?
☐ Yes ☐ No
- 13) Since you last registered has the Drug Enforcement Administration (DEA), or any state or International drug licensure/enforcement authority denied, revoked, suspended, restricted, limited, or otherwise disciplined a controlled substance registration certificate issued to you?
☐ Yes ☐ No
- 14) Since you last registered have you voluntarily or involuntarily surrendered a medical or osteopathic license, or controlled substance registration certificate issued to you?
☐ Yes ☐ No
- 15) Since you last registered has any hospital, hospital medical staff or any other health care entity revoked, suspended, restricted, limited, reprimanded, placed on probation or otherwise disciplined your staff privileges?
☐ Yes ☐ No
- 16) Since you last registered have you resigned your privileges or failed to renew privileges at a licensed hospital or from the medical staff of the hospital or any other health care entity, while under investigation or while you were subject to disciplinary proceedings by any of the entities noted above?
☐ Yes ☐ No
- 17) Since you last registered are any legal proceedings regarding licensure presently pending against you by any State, Federal or International licensure authority or any drug licensure/enforcement authority?
☐ Yes ☐ No
- 18) Since you last registered have you been removed, suspended, expelled or disciplined by any professional medical association or society?
☐ Yes ☐ No
- 19) Since you last registered have you been convicted of a felony or misdemeanor by any State, Federal or International court? Are any criminal charges presently pending against you in any of those courts?
☐ Yes ☐ No
- 20) Since you last registered to your knowledge, are you the subject of an investigation for a criminal act?
☐ Yes ☐ No
- 21) Since you last registered have you had to pay a judgment exceeding \$100,000 in a malpractice action or other civil action against your medical practice?
☐ Yes ☐ No
- 22) Are you currently in default on any student loan repayment obligations payable to the financial aid programs administered by the Kentucky Higher Education Assistance Authority?
☐ Yes ☐ No

I hereby state that the information contained in this application is true, accurate and complete to the best of my knowledge and belief. I understand any false information on my application may subject my license to disciplinary action pursuant to the Medical Practice Act.

Applicant Signature: _____ **Date:** _____

If you answer "Yes" to question 10 - 22, please attach a written explanation.

Only Completed Applications Will Be Processed; Incomplete Applications Or Applications Received Without Payment Will Be Returned.
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Application for Registration of Kentucky Medical/Osteopathic License for Year 2005

Name: _____

License No.: _____

The answers to these questions are exempt from public disclosure under KRS 61.878(1)(a) and KRS 311.619 and shall be subject to inspection only upon order of a court of competent jurisdiction, except that no court shall authorize the inspection by any party of any materials pertaining to civil litigation beyond that which is provided by the Kentucky Rules of Civil Procedure governing pretrial discovery. The answers to these questions may be considered by the Board and may be disclosed in any contested case proceeding, including a Show Cause proceeding, or appeal of a licensing decision based upon them.

“Illegal drug use” means the use of an illegally obtained controlled substance or dangerous drug; the term “illegal drug use” also means the use of a legally obtained controlled substance or dangerous drug which is not taken in accordance with the direction of the licensed health care professional who prescribed the controlled substance or dangerous drug.

(1.) Since you last registered, have you suffered from or been treated for any medical and/or psychiatric condition which might impair your ability to continue to practice medicine?
☐ Yes ☐ No

(2.) Since you last registered, have you suffered from or been treated for drug or alcohol abuse and/or dependency?
☐ Yes ☐ No

I hereby state that the information contained in this application is true, accurate and complete to the best of my knowledge and belief. I understand any false information on my application may subject my license to disciplinary action pursuant to the Medical Practice Act.

Applicant Signature: _____ Date: _____

If You Answer “Yes” To Questions (1) Or (2) Please Attach A Written Explanation.

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